

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 772. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08390										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
09										MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print) First Middle Last <b>Quitman Hurley Anstine, Jr.</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>June 23 1968</b>									
3. SEX <b>Male</b>										2b. HOUR <b>4:30</b>									
4. RACE <b>White</b>		5. DATE OF BIRTH <b>Jan. 5, 1925</b>		6. AGE (in years last birthday) <b>43</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <b>June 23 1968</b>									
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Dorchester</b>							
10. CITY OR TOWN OF DEATH <b>Cambridge</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give address) <b>D.O.A. Cambridge Md. Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Post Office employee</b>				12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>				13b. COUNTY <b>Dorchester</b>				13c. CITY OR TOWN <b>Cambridge</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
13e. STREET AND NUMBER <b>403 Talbot Ave.</b>				14. FATHER'S NAME First Middle Last <b>Quitman Hurley Anstine</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Helen Palmer</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>							
16b. SOCIAL SECURITY NO.				17. INFORMANT <b>Mrs. Florence W. Anstine, Cambridge, Md.</b>				ADDRESS <b>403 Talbot Ave.</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 Mins.</b>				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>				19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21a. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State				22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Mace Jr.</b>				EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <b>Cambridge, Md.</b>				22b. DATE SIGNED <b>6/24/68</b>							
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>				23b. DATE <b>June 25, 1968</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park, Cambridge, Md.</b>				23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Md.</b>							
24. FUNERAL DIRECTOR <b>R. Thorne</b>				ADDRESS <b>Cambridge, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 28 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

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June 23 1968

Cambridge, MA

White 100.5, 1968 43

Northampton

U.S.

Cambridge

200.5, 1968 43, 1968 43, 1968 43

Northampton, MA 403 Talbot Av.

Cambridge, MA 403 Talbot Ave.  
Mrs. Thomas V. Amadio, Cambridge, MA

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June 23, 1968 Northampton Memorial Park, Northampton, MA

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Cambridge, MA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Emerson Leroy Bolden			2a. DATE OF DEATH Month Day Year June 27 1968			2b. HOUR 10 35 P M	
3. SEX Male		4. RACE Colored		5. DATE OF BIRTH 6-27-68		6. AGE (In years last birthday) YRS. MONTHS DAYS 1 43	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Finchville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER							
14. FATHER'S NAME First Middle Last Emerson Leroy Smullen Jr.			15. MOTHER'S MAIDEN NAME First Middle Last Gloria Jean Bolden				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Gloria Bolden			
16c. ADDRESS Federalsburg, Md., RFD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> 486X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7630							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <del>this hospital</del> attended the deceased from 6-27, 1968, to 6-27, 1968, that (I) <del>see</del> last saw the deceased alive on 6-27, 1968, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-3-68	
22d. PHYSICIAN'S NAME (Type) Dr. J. Edwin Fassett				22e. ADDRESS 623 High Street Cambridge, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 29, 1968		23c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland	
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR JUL 10 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>HERMAN</b>		First Middle Last <b>BRAMBLE</b>		2a. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1968</b>		2b. HOUR M					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 7, 1892</b>		6. AGE (In years lost birth day) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester</b> Md.					
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cambridge Md. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer-ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Church Creek</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>None</b>			
14. FATHER'S NAME First <b>Noah</b> Middle <b>?</b> Last <b>Bramble</b>		15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>?</b> Last <b>?</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-16-4792</b>		17. INFORMANT Address <b>LeCompte Funeral Service records</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4200 Cerebral Palsy</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>2-17-59</b> , 19____, to <b>6-22-68</b> , 19____, that (I) (we) last saw the deceased alive on <b>6-22-68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Albert E. Bunker M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6-24-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Albert E. Bunker, M. D.</b>		22e. ADDRESS <b>200 Md. Ave., Cambridge, Maryland 21613</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 25, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Churchyard</b>		23d. LOCATION (City or Town) (County) (State) <b>Bishops Head, Maryland</b>					
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUL - 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

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# FOR STATE HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PWS-1005. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08398	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
MABLE H.W. BRAMBLE						ESTIMATED MONTH DAY YEAR			JUNE 7 1968 5:30		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR
FEMALE	WHITE	10-04-92	75					Month DAY Year			5:30
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			P.M.		
MARYLAND		USA					DORCHESTER			Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CAMBRIDGE			EASTERN SHORE STATE HOSPITAL			RETIRED					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD.			DORCHESTER		WINGATE						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
JOSEPH HENRY WINGATE			KATHERINE WINGATE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
NO			217-54-5074		RECORDS OF THE EASTERN SHORE STATE HOSPITAL						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Terminal Pneumonia										3 days	
DUE TO, OR AS A CONSEQUENCE OF											
(b) Fracture neck of femur										8 days	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
904.7											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		5/31 1968		Fall in hospital							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
		Hospital		Cambridge, Md. Clos.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				6/7/68			
JOHN MACE M.D.				DEPUTY MEDICAL EXAMINER							
				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Jun 10, 1968		Greenlawn Cemetery		Cambridge, Maryland					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
LeCompte Funeral Service, Cambridge, Maryland								JUN 14 1968		Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

08399

1. DECEASED-NAME (Type or print) <b>MARTIN</b>		First Middle Last <b>L. BRAMBLE</b>		2a. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>1968</b>		2b. HOUR <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 7, 1871</b>		6. AGE (In years last birthday) <b>96</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester</b>	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cambridge Md. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer-trapper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dirt-Fur</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Robbins</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>Zakie ? Bramble</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Brigette ? ?</b>		13e. STREET AND NUMBER <b>None</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service) <b>-- --</b>		16b. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT Address <b>LeCompte Funeral Service records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALNUTRITION</b> <b>2699</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 DAYS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2865 EXTREME AGE</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/24</b> , 19 <b>68</b> , to <b>6/24</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6/24</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>W.E. GURBY JR. M.D.</b>				22c. DATE SIGNED <b>6/25/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>W.E. GURBY JR.</b>				22e. ADDRESS <b>Cambridge Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 26, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sandy Island Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Robbins, Dor. Co., Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>LeCompte Funeral Service, Cambridge, Maryland</b>				25a. REC'D BY REGISTRAR <b>11-1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Figure 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last John Francis Brimer					2a. DATE OF DEATH Month Day Year JUNE 9 68			2b. HOUR 1 A.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 07-04-88		6. AGE (In years last birthday) 87 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.				
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Railroad Man		12b. KIND OF BUSINESS OR INDUSTRY Railroad.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 501 Walnut Street	
14. FATHER'S NAME First Middle Last Unknown John -- Brimer			15. MOTHER'S MAIDEN NAME First Middle Last Unknown Martha -- Turner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no --			16b. SOCIAL SECURITY NO. unk.		17. INFORMANT Address Medical Records - Eastern Shore State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4270 ACUTE CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONITIS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4341 DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 WK										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) GENERALIZED ARTERIOSCLEROSIS AND CHRONIC BRAIN SYNDROME										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8 JUNE, 1968, to 9 JUNE, 1968, that (I) (we) lost saw the deceased alive on 9 JUNE 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Sean M. Killoran M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 9 June 68		
22d. PHYSICIAN'S NAME (Type) SEAN M. KILLORAN M.D.					22e. ADDRESS 7415 BLAIR RD, WASHINGTON, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-11-1968		23c. NAME OF CEMETERY OR CREMATORY Nelson Cemetery		23d. LOCATION (City or Town) (County) (State) New Church - Accom. -Va.				
24. FUNERAL DIRECTOR Robert H. Watson					ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR JUN 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>IRVING R. BRYAN</b>			2a. DATE OF DEATH Month Day Year <b>06 30 68</b>			2b. HOUR <b>5:57 PM</b>					
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>03-25-14</b>		6. AGE (In years last birthday) <b>54 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester</b> Md.					
10. CITY OR TOWN OF DEATH <b>Rural-Cambridge</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Eastern Shore State Hosp</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>			13b. COUNTY <b>DOR.</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>704 Moore's ave.</b>		
14. FATHER'S NAME First Middle Last <b>LEONARD BRYAN</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ELIZABETH CHESTER</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>Med. Records</b> Address <b>Eastern Shore State Hosp</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with widespread metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>and bronchopneumonia left</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>1621</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W. Rieckert</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6-30-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>W. Rieckert</b>					22e. ADDRESS <b>E-New Market, Md</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7/6/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>VAUGHN</b>		23d. LOCATION (City or Town) (County) (State) <b>OLDFIELD DOR. MD.</b>					
24. FUNERAL DIRECTOR <b>Frederick C. Rieckert</b>					ADDRESS <b>CAMBRIDGE, MD</b>		25a. REC'D BY REGISTRAR DATE <b>JUL - 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John A. Judge</b>		

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UNITED STATES OF AMERICA

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DEPARTMENT OF THE ARMY

WASHINGTON, D.C.

TO THE SECRETARY OF THE ARMY  
FROM THE CHIEF OF THE BUREAU OF THE ARMY  
SUBJECT: [Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
08397		CERTIFICATE OF DEATH						08402			
1. DECEASED-NAME (Type or print)			First Middle Last			2c. DATE OF DEATH			2b. HOUR		
Ida Baker Carroff						Month 6 Day 16 Year 68			9:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		white		8/11/1878			89 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Md.		A.S.H.					Dorchester				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge			Clasgow Nursing Home			Housework					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md			Dor.			Hurlock			Academy		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
James Baker			Elizabeth Towers								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			212-07-5446			Mrs W. F. E. Loftin			Marion, N.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Pulmonary										C. 10	
DUE TO, OR AS A CONSEQUENCE OF											
(b) Chronic Bronchitis											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Scurvy & thrombosis											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
334X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 9-3, 19 67, to 6-16, 19 68, that (I) (we) last saw the deceased alive on 6-16, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
Richard G. Bilodeau						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			6-16-68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
RICHARD G. BILDEAU						CAMBRIDGE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			6/19/68		Washington			Hurlock, Dor, Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Ruth S. Shillaghy, East New Market						JUN 26 1968			Charles Judge		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> <span>08398</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>08403</span> </div>									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Ruth Helen Dayton						Month Day Year June 17 1968			5A M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		March 15, 1930			38 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.				Dorchester Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cambridge			Cambridge-Md. Hospital			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Md.			St. Marys		Leonardtown		YES		Route #2
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Russell G. Stack			Ruth Bangert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No					Earl F. Dayton RD 2 Leonardtown Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of right breast with metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>breast with metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>174X</u>									3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
170X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
Aug. 1966		CA breast			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County	State
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from Aug 1966 to Jan 17, 1968, that (I) (we) lost the deceased alive on June 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
Lewis M. Burdette					17 June 68				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Lewis M. Burdette					4 Aurora St. Cambridge, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		6/19/68		E. New Market Cemetery		E. New Market Dor. Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Kenneth R. Thomas Jr. Cambridge Md.					DATE JUN 26 1968		Charles Judge		

DATE OF DEATH: 1968 JUN 17

TIME OF DEATH: 10:00 AM

PLACE OF DEATH: HOME

CAUSE OF DEATH: HEART DISEASE

AGE: 75

SEX: MALE

RACE: WHITE

EDUCATION: HIGH SCHOOL

OCCUPATION: RETIRED

RELIGION: METHODIST

USUAL RESIDENCE: 1234 MAIN ST, ALBANY, NY

DATE OF BIRTH: 1900 JAN 1

PLACE OF BIRTH: ALBANY, NY

DATE OF DEATH: 1968 JUN 17

TIME OF DEATH: 10:00 AM

PLACE OF DEATH: HOME

CAUSE OF DEATH: HEART DISEASE

AGE: 75

SEX: MALE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 11-5-64  
30M REV. 1/768

08399										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08404																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										2b. HOUR																																							
John Henry Delaha										6-2-68										2:45 AM																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Male										White										7-19-76										91 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
Maryland										USA																				Dorchester										Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Cambridge										Eastern Shore State Hospital										Sailor-waterman										waterman																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
Md.										Dorchester										Church Creek																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										Address																																							
First Middle Last										First Middle Last																																																	
Henry Delaha										Anna Dzik																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes ( ) or unknown ( )										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
										213-22-7826										Mrs Nora Wallace										Church Creek Md.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART 1. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF																																																	
4369																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b)										GENERALIZED ARTERIOSCLEROSIS										2 1/2 yrs.																													
										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
331 OLD CVA -																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that <del>the</del> (this hospital) attended the deceased from 12-17-65 to 6-2-68, 19, that <del>it</del> (we) last saw the deceased alive on 6-2-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Edward Lewis										6-2-68																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
EDWARD LEWIS, M.D.										ESSH, CAMBRIDGE, MD -																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										6/4/68										East New Market										East New Market, Dor. Md.																													
24. FUNERAL DIRECTOR										ADDRESS										25. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Arthur S. Holloughby										East New Market										JUN 5 1968										Charles Judge																													

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>08400</div> <div> <div>08405</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> </div>											
<div>1. DECEASED-NAME (Type or Print)</div> <div>First Middle Last</div> <div>Ferdinand Fortthman</div>						<div>2a. DATE KNOWN OF DEATH</div> <div> <input checked="" type="checkbox"/> Month Day Year  <input type="checkbox"/> ESTI-MATED </div> <div>6-24-1968</div>					
<div>3. SEX</div> <div>M</div>		<div>4. RACE</div> <div>W</div>		<div>5. DATE OF BIRTH</div> <div>May 15, 1915</div>		<div>6. AGE (in years last birthday)</div> <div>53 YRS.</div>		<div>IF UNDER 1 YEAR</div> <div>MONTHS DAYS HOURS MIN.</div>		<div>2c. DATE PRONOUNCED DEAD</div> <div>Month Day Year</div> <div>6 24 1968</div>	
<div>7a. BIRTHPLACE (State or foreign country)</div> <div>Penna</div>			<div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div>			<div>8. MARRIED</div> <div> <input checked="" type="checkbox"/> NEVER MARRIED  <input type="checkbox"/> WIDOWED  <input type="checkbox"/> DIVORCED </div>			<div>9. COUNTY OF DEATH</div> <div>Dorchester Md.</div>		
<div>10. CITY OR TOWN OF DEATH</div> <div>near Cambridge</div>				<div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div></div>				<div>12a. USUAL OCCUPATION (Kind of work done during last 12 months)</div> <div>State assessment</div>			
<div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>Md.</div>				<div>13b. COUNTY</div> <div>Dorchester</div>		<div>13c. CITY OR TOWN</div> <div>Andrews</div>		<div>13d. INSIDE CITY LIMITS?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>		<div>13e. STREET AND NUMBER</div> <div></div>	
<div>14. FATHER'S NAME</div> <div>First Middle Last</div> <div>James Fortthman</div>						<div>15. MOTHER'S MAIDEN NAME</div> <div>First Middle Last</div> <div>Cora Baungardner</div>					
<div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>no</div>				<div>16b. SOCIAL SECURITY NO.</div> <div>(If yes give war or dates of service)</div>		<div>17. INFORMANT ADDRESS</div> <div>Mrs. Ferdinand Fortthman, Andrews, Md.</div>					
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Gun shot wound of chest</div> <div>955x</div> <div> <div> <div>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</div> <div> <div>(b)</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> </div> <div> <div>(c)</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> </div> </div> </div>										<div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div>Instant</div>	
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</div> <div>976x</div>											
<div>19a. DATE OF OPERATION</div> <div></div>				<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</div> <div></div>				<div>20. AUTOPSY?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>			
<div>21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/></div> <div>CAUSE OF DEATH</div>				<div>21b. TIME OF INJURY Month, Day, Year</div> <div>HOUR A.M. P.M.</div> <div>? 6/24/1968</div>		<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div> <div>Shot self with shotgun</div>					
<div>21d. INJURY OCCURRED</div> <div>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></div>		<div>21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div> <div>chicken house-home</div>		<div>21f. LOCATION Street or R.F.D. No.</div> <div>Andrews</div>				<div>City or Town</div> <div>Dor.</div>		<div>State</div> <div>Md.</div>	
<div>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></div>											
<div>ACTUAL SIGNATURE</div> <div>EXAMINER'S NAME (Type)</div> <div>John Mace Jr.</div>						<div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>ADDRESS (Street, city, town, or county)</div>					
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>		<div>23b. DATE</div> <div>June 27, 1968</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Sandy Island</div>				<div>23d. LOCATION (City or Town) (County) (State)</div> <div>Dorchester, Md.</div>			
<div>24. FUNERAL DIRECTOR ADDRESS</div> <div>Charles V. Moore, Denton, Md.</div>						<div>25a. REC'D BY REGISTRAR</div> <div>DATE</div> <div>JUL - 1 1968</div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>			

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08400

IN THE  
CITY OF  
NEW YORK

Name of Debtor		Name of Creditor	
Address of Debtor		Address of Creditor	
City and State of Debtor		City and State of Creditor	
Date of Filing		Date of Maturity	
Amount of Debt		Amount of Debt	
Interest Rate		Interest Rate	
Collateral		Collateral	
Signature of Debtor		Signature of Creditor	
Signature of Trustee		Signature of Trustee	
Notary Public		Notary Public	
Date of Execution		Date of Execution	
Place of Execution		Place of Execution	
Witnesses		Witnesses	
Judge of Court		Judge of Court	
Court of Record		Court of Record	
County of New York		County of New York	
State of New York		State of New York	
United States of America		United States of America	
Federal Bankruptcy Court		Federal Bankruptcy Court	
District of Southern District of New York		District of Southern District of New York	
Southern District of New York		Southern District of New York	
New York City		New York City	
New York County		New York County	
New York State		New York State	
United States		United States	
World		World	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

08401										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08406																																							
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																													
SUDIA										JACKSON GREEN GIBSON										JUNE 6 1968										7:15 p M																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
FEMALE										NEGROID										FEB. 6, 1877										91 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
MARYLAND										USA																				DORCHESTER										Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
CAMBRIDGE										CAMBRIDGE MD. HOSP., INC.										LABORER																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. CITY OR TOWN										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. STREET AND NUMBER																													
MARYLAND										DORCHESTER										CAMBRIDGE										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										806 HIGH STREET																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address									
THOMAS H. JACKSON										MARY										NO										217-30-8653										WELDON GREEN										806 HIGH STREET 21613									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										19. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterioscleroti Cardiovascular renal																																																											
4120 DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) disease																																																	
										DUE TO, OR AS A CONSEQUENCE OF																																																	
										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
4427																																																											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from Nov. 28, 1967, to June 6, 1968, that (I) (we) last saw the deceased alive on June 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED										22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																													
										June 7, 1968										J. EDWIN FASSETT, M.D.										623 HIGH STREET CAMBRIDGE, MD. 21613																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
BURIAL										6/9/68										WAUGH										CAMBRIDGE DOR. MD.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR DATE										25b. REGISTRAR'S SIGNATURE																													
Ludwick C. Delair										CAMBRIDGE, MD.										JUN 12 1968										Charles Judge																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>08402</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>08407</div>															
1. DECEASED-NAME (Type or print) <b>Mary</b>						First		Middle		Last		2a. DATE OF DEATH <b>June</b> Month <b>25</b> Day <b>1968</b> Year		2b. HOUR M	
3. SEX <b>Female</b>			4. RACE <b>Negro</b>			5. DATE OF BIRTH <b>Apr. 12, 1908</b>			6. AGE (In years last birthday) <b>60</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Dorchester</b>			Md.			
10. CITY OR TOWN OF DEATH <b>Cambridge</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cambridge Maryland</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Dorchester</b>			13c. CITY OR TOWN <b>Cambridge</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>1008 Phillips St.</b>			
14. FATHER'S NAME <b>General Freeman</b>						15. MOTHER'S MAIDEN NAME <b>Mary Skinner</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>226 09 6859</b>			17. INFORMANT <b>Ernest Lee Watford</b>			Address <b>1008 Phillips St. Cambridge, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pernicious Anemia</b> <b>2810</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2900</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 26, 1964</b> , to <b>June 25, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 25, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE 						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>June 28, 1968</b>						
22d. PHYSICIAN'S NAME (Type) <b>Dr. J. Edwin Fassett</b>						22e. ADDRESS <b>High St, Cambridge, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>6/30/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>			23d. LOCATION (City or Town) (County) (State) <b>Cambridge Dorchester Md.</b>						
24. FUNERAL DIRECTOR <b>Barbara L. Dashiell</b>						ADDRESS <b>426 Dover</b>			25a. REC'D BY REGISTRAR DATE <b>JUL - 1 1968</b>			25b. REGISTRAR'S SIGNATURE 			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515  
30M REV 1/68

08403				MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH				08408			
1. DECEASED-NAME (Type or print) First Middle Last Richard HAASS				2a. DATE OF DEATH Month Day Year 6 3 1968				2b. HOUR 2:45 AM			
3. SEX male		4. RACE white		5. DATE OF BIRTH 7-10-1887				6. AGE (In years lost birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester X Md.					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Butcher & Farmer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER None			
14. FATHER'S NAME First Middle Last Michael HAASS				15. MOTHER'S MAIDEN NAME First Middle Last Marie Not listed							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown UNKNOWN		16b. SOCIAL SECURITY NO. Not listed		17. INFORMANT Address Eastern Shore State Hosp (Med. Records)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 PROBABLE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS AT LEAST ONE MONTH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Brain Syndrome; Chronic Bronchitis; Emphysema-											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that (this hospital) attended the deceased from 5-20-1968, to 6-3-1968, that (we) last saw the deceased alive on 6-3-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. Lewis				DEGREE EDWARD LEWIS JR. MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-3-68			
22d. PHYSICIAN'S NAME (Type) EDWARD LEWIS JR. MD				22e. ADDRESS ESSH, CAMBRIDGE, MD-							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-5-68		23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City or Town) (County) (State) Greensboro, Caroline Md.					
24. FUNERAL DIRECTOR John E. Boulais				ADDRESS Greensboro Md.		25a. REC'D BY REGISTRAR JUN 5 1968		25b. REGISTRAR'S SIGNATURE John E. Boulais			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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08404		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08409	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last PERCY Lloyd HENRY			2a. DATE OF DEATH Month Day Year JUNE 20, 1968			2b. HOUR 2:30 P. M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 5/23/90		6. AGE (In years last birthday) 78 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH DORCHESTER Md.	
10. CITY OR TOWN OF DEATH RURAL CAMBRIDGE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Carpenter		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY DOR.		13c. CITY OR TOWN EAST NEW MARKET		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last GEORGE M. HENRY		15. MOTHER'S MAIDEN NAME First Middle Last LULA Meers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 212-16-7497A		17. INFORMANT HOSPITAL RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 485X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 491X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6/8, 19 68, to 6/20, 19 68, that (I) (we) last saw the deceased alive on 6/20, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE F. M. Dominguez, M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/20/68	
22d. PHYSICIAN'S NAME (Type) FELIPE M. DOMINGUEZ, M.D.				22e. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6/23/68		23c. NAME OF CEMETERY OR CREMATORY East New Market		23d. LOCATION (City or Town) (County) (State) East New Market Dor Md	
24. FUNERAL DIRECTOR Duth A. Melloway		ADDRESS East New Market		25a. REC'D BY REGISTRAR DATE JUN 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>08405</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>08410</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>											
1. DECEASED-NAME (Type or print) <b>GOLDSBOROUGH</b> <b>Z.</b> <b>JAMES</b>						2a. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1968</b>			2b. HOUR M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>December 15, 1899</b>			6. AGE (In years lost birthday) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester</b> Md.					
10. CITY OR TOWN OF DEATH <b>Near Cambridge</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Town Point, RFD #3</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Dirt</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Town Point, RFD #3</b>			
14. FATHER'S NAME First Middle Last <b>Joseph H. James</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Clara M. Lankford</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>- - -</b>		16b. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT Address <b>LeCompte Funeral Service records</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Constriction heart failure + H. pneumonia</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>years</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>June 29, 1968</b> , to <b>June 30, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 29, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>James D. Thompson</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/2/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>James D. Thompson, M.D.</b>		22e. ADDRESS <b>602 Locust St., Cambridge, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 2, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>East New Market, Maryland</b>				
24. FUNERAL DIRECTOR ADDRESS <b>LeCompte Funeral Service, Cambridge, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>JUL - 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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4522 • J. Neurosci., July 26, 2006 • 26(30):4517–4524

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between Pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1514  
30M REV. 7/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |  |   |  |
|--|--|--|--|---|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |   |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |   |  |
| 1. DECEASED-NAME (Type or print) <b>DAVID <del>W. BABY BOY</del> RAY</b>   |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>19</b> Year <b>1968</b>                               |  | 2b. HOUR <b>11:17</b> M <b>A</b>                           |   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH<br><b>June 19, 1968</b>  |  | 6. AGE (In years last birthday) YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Dorchester</b> Md.  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Cambridge</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cambridge Md. Hospital</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>              |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  |  | 13b. COUNTY <b>Dorchester</b>  |   | 13c. CITY OR TOWN <b>Cambridge</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>112 High Street</b> |  |
| 14. FATHER'S NAME First <b>Ray</b> Middle <b>Francis</b> Last <b>Justice</b>   |  |  | 15. MOTHER'S MAIDEN NAME First <b>Donna</b> Middle <b>Jean</b> Last <b>Meredith</b>                        |   |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO. <b>None</b>   |   | 17. INFORMANT Address <b>LeCompte Funeral Service records</b>  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>STILLBORN PREMATURE</b><br><b>777X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>776X</b>  |  |  |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |   |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-19</b> , 19 <b>68</b> , to <b>6-19</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6-19</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |  |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE <b>James F. McCarter</b>  |  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED <b>6-21-68</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>JAMES F. McCARTER, MD.</b>   |  |  |  |   | 22e. ADDRESS <b>P.O. 386 CAMBRIDGE, MD. 21613</b>  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>June 20 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>                            |  |  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>LeCompte Funeral Service, Cambridge, Maryland</b>  |  |  |  |   | 25a. REC'D BY REGISTRAR <b>JUN 24 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |   |  |

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Article 11. *Amended*

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1. *Introduction*

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1. *Introduction*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, if any, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>08407</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>08412</span> </div>   |  |  |   |  |                                     |  |  |  |   |   |                             |
|--|--|--|---|--|-------------------------------------|--|--|--|---|---|-----------------------------|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Alice R. Leishear</b>   |  |  |   |  |                                     | 2a. DATE OF DEATH Month Day Year<br><b>6 27 68</b>   |  |  | 2b. HOUR<br><b>4:45AM</b>                       |   |                             |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br><b>8-10-71</b>   |                                     |  | 6. AGE (In years last birthday)<br><b>96</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS                     |   | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                 |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH<br><b>Dorchester</b>  |  |  | X Md.   |   |                             |
| 10. CITY OR TOWN OF DEATH<br><b>Cambridge (Rural)</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Eastern Shore State Hosp</b> |  |                                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>                            |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-          |   |                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Dorchester</b>  |  | 13c. CITY OR TOWN<br><b>Hurlock</b> |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>S. MAIN Street</b> |   |                             |
| 14. FATHER'S NAME First Middle Last<br><b>Thomas Colein</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Elexina Colein</b>  |                                     |  |  |  |   |   |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>UNKNOWN</b>   |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>NOT listed</b>  |                                     | 17. INFORMANT Address<br><b>Eastern Shore State Hosp (Medical Records)</b>   |  |  |   |   |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>486X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>492X</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |  |                                     |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 Hours</b> |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>athero Sclerotic heart disease, Rheumatoid arthritis, Hiatal Hernia</b>   |  |  |   |  |                                     |  |  |  |   |   |                             |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  |                                     | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |   |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                     |  |  |  |   |   |                             |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.   |                                     | City or Town   |  | County   |   | State   |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-8-68</b> , 19__, to <b>6-27-68</b> , 19__, that (I) (we) last saw the deceased alive on <b>6-26-68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |   |  |                                     |  |  |  |   |   |                             |
| 22b. SIGNATURE<br><b>Stephen H Kaufman MD</b>  |  |  |   |  |                                     | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6-27-68</b>                                   |   |   |                             |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Stephen H Kaufman</b>   |  |  |   |  |                                     | 22e. ADDRESS<br><b>1604 N Calvert St Balto Md</b>  |  |  |   |   |                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>July 1, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>   |                                     | 23d. LOCATION (City or Town) (County) (State)<br><b>Frederick Ave. Balto. Md.</b>  |  |  |   |   |                             |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard</b>   |  |  |   | ADDRESS<br><b>4107 Wilkens Ave. 21229</b>  |                                     | 25a. REC'D BY REGISTRAR<br><b>JUL - 1 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>                 |   |   |                             |

THIS IS TO CERTIFY THAT  
 the within and foregoing is a true and correct copy  
 of the original as the same appears from the records  
 of the State of New York.

IN WITNESS WHEREOF, I have hereunto set my hand  
 and the seal of the State of New York, at Albany,  
 this 10th day of June, 1907.

GOVERNOR

COMMISSIONER

CLERK

DEPUTY CLERK

RECORDS

GENERAL

LEGISLATIVE

JUDICIAL

EXECUTIVE

FINANCIAL

EDUCATIONAL

AGRICULTURAL

INDUSTRIAL

COMMERCE

NAVY

MILITARY

RELIGIOUS

SCIENCE

ARTS

LITERATURE

LANGUAGE

PHILOSOPHY

RELIGION

ETHICS

LOGIC

METAPHYSICS

SCIENCE

PHILOSOPHY

RELIGION

ETHICS

LOGIC

METAPHYSICS

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

08413

|   |  |   |   |   |   |  |  |   |  |  |  |                                   |  |
|---|--|---|---|---|---|--|--|---|--|--|--|-----------------------------------|--|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Elsie Pauline McGrath</b>  |  |   | 2a. DATE OF DEATH Month Day Year<br><b>June 4 1968</b>  |   | 2b. HOUR<br><b>3 A M</b>  |  |  |   |  |  |  |                                   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>                     |   | 5. DATE OF BIRTH<br><b>Sept. 26, 1901</b>   |   | 6. AGE (In years last birthday) YRS.<br><b>66</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br><b></b>  |  | IF UNDER 24 HRS. HOURS MIN.<br><b></b>                         |  |                                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Kansas</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Dorchester Md.</b>  |  |   |  |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cambridge</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Cambridge-Md. Hospital</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>                            |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>   |  |  |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br><b>Dorchester</b>  |   |   | 13c. CITY OR TOWN<br><b>Church Creek</b>   |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b></b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Gustav Kurth</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Fredericka Talman</b>  |   |  |  |   |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b></b>   |   | 17. INFORMANT Address<br><b>Mr. William R. McGrath Church Creek Md.</b>  |  |   |  |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br><b>431.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>17 days</b> |  |                                   |  |
|   |  |   |   |   |   |  |  |   |  |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>331X</b>   |  |   |   |   |   |  |  |   |  |  |  |                                   |  |
| 19a. DATE OF OPERATION<br><b></b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>   |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b></b> |  |  |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)<br><b></b>   |  |   | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.<br><b>19</b>  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)<br><b></b>   |  |   |  |  |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br><b></b>                       |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b></b>  |  |   |  |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/19/68</b> , 19____, to <b>6/4/68</b> , 19____, that (I) (we) last saw the deceased alive on <b>6/3/68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |   |   |   |   |  |  |   |  |  |  |                                   |  |
| 22b. SIGNATURE<br><b>John Mace Jr.</b>  |  |   |   |   |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/4/68</b>   |  |  |  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>John Mace Jr. M.D.</b>   |  |   |   |   |   | 22e. ADDRESS<br><b>Cambridge, Md.</b>  |  |   |  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>June 6, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>E. New Market Cemetery</b> |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>E. New Market Dor. Md.</b>  |  |  |  |                                   |  |
| 24. FUNERAL DIRECTOR<br><b>Heather L. Thomas</b>  |  |   |   |   |   | ADDRESS<br><b>Cambridge Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUN 10 1968</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>               |  |                                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |         |  |                  |                                    |  |   |   |  |  |
|---|--|---------|--|------------------|------------------------------------|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |         |  |                  |                                    |  |   |   |  |  |
| CERTIFICATE OF DEATH  |  |         |  |                  |                                    |  |   |   |  |  |
| 1. DECEASED-NAME (Type or print)  |  |         | First  |                  | Middle                             |  | Last  |   | 2a. DATE OF DEATH  |  |
| GEORGE  |  |         | W.   |                  | NICHOLS                            |  | JUNE  |   | Month Day Year 27, 1968  |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH |                                    |  | 6. AGE (In years last birthday)                                     |   | 2b. HOUR   |  |
| MALE  |  | NEGROID |  | MAY 5, 1899      |                                    |  | 89 YRS.   |   | 11:15P   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |  |
| MARYLAND  |  |         | USA  |                  |                                    |  |   | DORCHESTER Md.  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |
| CAMBRIDGE   |  |         | CAMBRIDGE MD. HOPITAL, INC.  |                  |                                    | LABORER  |   |   | RAILROAD   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)   |  |         | 13b. CITY OR TOWN  |                  |                                    | 13c. INSIDE CITY LIMITS?   |   | 13e. STREET AND NUMBER  |  |  |
| MARYLAND  |  |         | DORCHESTER   |                  |                                    | CAMBRIDGE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 1005 CAMELIA STREET   |  |  |
| 14. FATHER'S NAME   |  |         | 15. MOTHER'S MAIDEN NAME   |                  |                                    |  |   |   |  |  |
| First Middle Last JAMES OLIVER NICHOLS  |  |         | First Middle Last MARY CORNISH   |                  |                                    |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  |         | 16b. SOCIAL SECURITY NO.   |                  |                                    | 17. INFORMANT  |   |   | Address  |  |
| NO  |  |         | 717-07-3699  |                  |                                    | LOLITA CLARK   |   |   | 706 LINCOLN TER. 21613   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  |                  |                                    |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |  |         |  |                  |                                    |  |   |   |  |  |
| IMMEDIATE CAUSE (a) <u>Uremia</u>   |  |         |  |                  |                                    |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |                  |                                    |  |   |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |         |  |                  |                                    |  |   |   |  |  |
| (b) <u>C.V.A. - Hypertensive cardiovascular renal</u>   |  |         |  |                  |                                    |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |                  |                                    |  |   |   |  |  |
| (c) <u>disease</u>  |  |         |  |                  |                                    |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |         |  |                  |                                    |  |   |   |  |  |
| 331X  |  |         |  |                  |                                    |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |                                    |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |         |  |                  |                                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |         | 21b. TIME OF INJURY  |                  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |
|   |  |         | HOUR A.M. Month Day Year P.M. 19   |                  |                                    |  |   |   |  |  |
| 21d. INJURY OCCURRED  |  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  |                                    | 21f. LOCATION  |   | City or Town  |  | State  |
| While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>   |  |         |  |                  |                                    | Street or R.F.D. No.   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 17, 1968</u> , to <u>June 29, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 19, 1968</u> , and that in (my) (our) opinion death occurred on the <u>date and hour</u> and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |  |                  |                                    |  |   |   |  |  |
| 22b. SIGNATURE  |  |         |  |                  |                                    | DEGREE   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED                             |
|   |  |         |  |                  |                                    |  |   |   |  | 7-3-68                                       |
| 22d. PHYSICIAN'S NAME (Type)  |  |         |  |                  |                                    | 22e. ADDRESS   |   |   |  |  |
| EDWIN FASSETT, M.D.   |  |         |  |                  |                                    | 623 HIGH ST., CAMBRIDGE, Md.   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |
| BURIAL  |  |         | 7/3/68   |                  | BETHEL                             |  |   | CAMBRIDGE DOR. MD.  |  |  |
| 24. FUNERAL DIRECTOR  |  |         |  |                  |                                    | ADDRESS  |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                   |
|   |  |         |  |                  |                                    | CAMBRIDGE, MD.   |   | DATE JUL - 9 1968   |  |  |

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UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE      FEDERAL BUREAU OF INVESTIGATION      WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-388610)      FROM : SAC, NEW YORK (100-100000)      SUBJECT: [Illegible]

RE: NEW YORK TELETYPE TO BUREAU, MAY 1, 1964.

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE MATTER:

ON MAY 1, 1964, THE NEW YORK OFFICE RECEIVED A TELEPHONE CALL FROM [Illegible]

WHO STATED THAT HE HAD INFORMATION CONCERNING THE [Illegible]

ACTIVITIES OF [Illegible] IN NEW YORK CITY.

100-388610

*[Handwritten signature]*

COPIES OF THIS REPORT WILL BE FURNISHED TO THE [Illegible]

100-388610

100-388610

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1-64  
30M REV 1-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |  |   |        |   |  |  |   |
|--|--|---|--------|---|--|--|---|
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br><b>ALBERT</b>  | Middle | Lost<br><b>OSPERLUNG</b>  | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>8</b> Year <b>1968</b> |  | 2b. HOUR<br><b>8:10</b>   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |        | 5. DATE OF BIRTH<br><b>unk</b>  |  | 6. AGE (In years last birthday)<br><b>84</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Finland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Dorchester</b> Md.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Cambridge</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Cambridge Md. Hospital</b> |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Caretaker-Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>- - -</b>  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Dorchester</b>  |        | 13c. CITY OR TOWN<br><b>Cambridge</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>13e. STREET AND NUMBER<br><b>301 Maryland Avenue</b> |   |
| 14. FATHER'S NAME<br>First Middle Lost<br><b>unk</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Lost<br><b>unk</b>   |        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown (If yes give war or dates of service)<br><b>unk</b>                                     |  |  |   |
| 16b. SOCIAL SECURITY NO.<br><b>unk</b>   |  | 17. INFORMANT<br><b>LeCompte Funeral Service records</b>  |        |   |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>4120 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 DAYS</b><br><b>12+ DAYS</b> |  |   |        |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>443X <b>GENERALIZED ARTERIO SCLEROSIS</b>  |  |   |        |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-7</b> , 19 <b>68</b> , to <b>6-8</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6-7</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |        |   |  |  |   |
| 22b. SIGNATURE<br><b>Donald R. McWilliams, MD</b>  |  | DEGREE  |        | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>6-14-68</b>   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Donald R. McWilliams, M. D.</b>   |  | 22e. ADDRESS<br><b>P. O. Box 248, East New Market, Maryland</b>   |        |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jun 10 1968</b>   |        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dorchester Memorial Park</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cambridge, Maryland</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>LeCompte Funeral Service, Cambridge, Maryland</b>   |  | ADDRESS   |        | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 18 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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Table 13

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Exhibit 100-240

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doi:10.1017/S0022278X09990099

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in space 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |                  |  |                                |  |   |  |                          |  |  |          |
|--|---------|------------------|--|--------------------------------|--|---|--|--------------------------|--|--|----------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |                  |  |                                |  |   |  |                          |  |  |          |
| 1. DECEASED-NAME<br>(Type or Print)  |         |                  | First Middle Last  |                                |  | 2a. DATE KNOWN OF DEATH   |  |                          | 2b. HOUR   |  |          |
| Lula Todd Phillips   |         |                  |  |                                |  | Month Day Year  |  |                          | 11 AM  |  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD |  |  | 2d. HOUR |
| Female   | White   | May 22, 1892     | 76 YRS.  |                                |  |   |  | Month Day Year           |  |  | M        |
| 7a. BIRTHPLACE (State or foreign country)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |                          | 9. COUNTY OF DEATH   |  |          |
| Md.  |         |                  | U.S.   |                                |  |   |  |                          | Dorchester Md.   |  |          |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |                          | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |
| Cambridge  |         |                  | 213 Dorchester Ave.  |                                |  | Homemaker   |  |                          |  |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE  |         |                  | 13b. COUNTY  |                                |  | 13c. CITY OR TOWN   |  |                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |
| Md.  |         |                  | Dorchester   |                                |  | Toddville   |  |                          |  |  |          |
| 14. FATHER'S NAME  |         |                  | 15. MOTHER'S MAIDEN NAME   |                                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |                          | 16b. SOCIAL SECURITY NO.   |  |          |
| William Otto Hughes  |         |                  | Matilda Dayton   |                                |  | No  |  |                          |  |  |          |
| 17. INFORMANT  |         |                  | ADDRESS  |                                |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |          |
| Mr. Philip Todd  |         |                  | Wingate Md.  |                                |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>4109<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                          | Instant  |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |                  |  |                                |  |   |  |                          |  |  |          |
| 4201   |         |                  |  |                                |  |   |  |                          |  |  |          |
| 19a. DATE OF OPERATION   |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                                |  | 20. AUTOPSY?  |  |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M.                    |                                |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |                          |  |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                |  | 21f. LOCATION Street or R.F.D. No.  |  |                          | City or Town County State  |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  |  |                                |  |   |  |                          |  |  |          |
| ACTUAL SIGNATURE   |         |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |                                |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |                          | 22b. DATE SIGNED   |  |          |
| EXAMINER'S NAME (Type)   |         |                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |                                |  | ADDRESS (Street, city, town, or county)   |  |                          | Cambridge, Md.   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                  | 23b. DATE  |                                |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                          | 23d. LOCATION (City or Town) (County) (State)  |  |          |
| Burial   |         |                  | 6/22/68  |                                |  | Zion Churchyard   |  |                          | Toddville Dor. Md.   |  |          |
| 24. FUNERAL DIRECTOR   |         |                  | ADDRESS  |                                |  | 25a. REC'D BY REGISTRAR   |  |                          | 25b. REGISTRAR'S SIGNATURE   |  |          |
| Kenneth L. Thomas Jr.  |         |                  | Cambridge Md. 21613  |                                |  | DATE JUN 26 1968  |  |                          | Charles Judge  |  |          |

01280

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
30M REV. 12-48

| MIDDLE  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                                |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|--------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                                |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                                |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>LOIS  |  |  | Middle<br>BRADLEY   |  |  | Last<br>PRICE  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>June 17, 1968    |  |  | 2b. HOUR<br>9:55 PM            |  |  |
| 3. SEX<br>Female  |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>July 6, 1893  |  |  | 6. AGE (In years last birthday)<br>74 YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                          |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Dorchester Md.   |  |  |   |  |  |                                |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cambridge  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Cambridge Md. Hospital |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Seamstress   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Factory   |  |  |   |  |  |                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |  | 13b. COUNTY<br>Dorchester  |  |  | 13c. CITY OR TOWN<br>Cambridge  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>704 Travers Street            |  |  |                                |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Jesse ? Bradley   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Octavia ? ?   |  |  |   |  |  |  |  |  |   |  |  |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>214-07-7680  |  |  | 17. INFORMANT<br>LeCompte Funeral Service records   |  |  | Address  |  |  |   |  |  |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Breast carcinoma, metastatic</u><br>174X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 years |  |  |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>170X  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                                |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |  |   |  |  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |   |  |  |                                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |  |  |  |   |  |  |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-10, 1968, to 6-17, 1968, that (I) (we) last saw the deceased alive on 6-17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |                                |  |  |
| 22b. SIGNATURE<br>Richard G. Bilodeau   |  |  |  |  |  |   |  |  |  |  |  | 22c. DATE SIGNED<br>6-18-68                             |  |  |                                |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>RICHARD G. BILODEAU   |  |  |  |  |  | 22e. ADDRESS<br>CAMBRIDGE, MD.  |  |  |  |  |  |   |  |  |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>June 19, 1968   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dorchester Memorial Park  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Cambridge, Maryland                 |  |  |   |  |  |                                |  |  |
| 24. FUNERAL DIRECTOR<br>LeCompte Funeral Service, Cambridge, Maryland   |  |  |  |  |  | 25a. RECD BY REGISTRAR<br>DATE JUN 24 1968  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |  |   |  |  |                                |  |  |

MEDICAL CERTIFICATION

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UNIVERSITY OF CALIFORNIA

00018

June 15, 1968

PRICE

LIBRARY

NOTE

July 6, 1968

DATE

TIME

UNIVERSITY OF CALIFORNIA

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DATE

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                         |  |  |  |   |  |                                   |   |  |  |
|---|--|-------------------------|--|--|--|---|--|-----------------------------------|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |  |  |   |  |                                   |   |  |  |
| 1. DECEASED NAME<br>(Type or Print)   |  |                         | First<br><b>PERRY</b>  |  |  | Middle<br><b>RIGGINS</b>  |  |                                   | Last<br><b>RIGGINS</b>  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Negro</b> |  | 5. DATE OF BIRTH<br><b>Oct. 25, 1924</b> |  | 6. AGE (In years last birthday)<br><b>43</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS |   | IF UNDER 24 HRS<br>HOURS<br>MIN              |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Norfolk, Va.</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                   | 2c. DATE PRONOUNCED DEAD<br>Month <b>June</b> Day <b>22</b> Year <b>1968</b>                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hurlock</b>   |  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Harrison Ferry Road</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Day Laborer</b>  |  |                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Canning Factory</b>                                     |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |                         | 13b. COUNTY<br><b>Dorchester</b>   |  |  | 13c. CITY OR TOWN<br><b>Hurlock</b>   |  |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>First<br><b>Unknown</b>  |  |                         | Middle<br><b>Unknown</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>Unknown</b>   |  |                                   | Middle<br><b>Unknown</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes?</b>  |  |                         | 16b. SOCIAL SECURITY NO.<br><b>214-32-5291</b>   |  |  | 17. INFORMANT<br>ADDRESS<br><b>Edna Wright, Hurlock, Maryland, R.F.D. #2</b>  |  |                                   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b><br><b>485X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>with abscess formation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>491X</b> |  |                         |  |  |  |   |  |                                   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                   |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |                                   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  |  | 21f. LOCATION Street or R.F.D. No.  |  |                                   | City or Town<br>County<br>State   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>  |  |                         |  |  |  |   |  |                                   |   |  |  |
| ACTUAL SIGNATURE<br><b>W. Rieckert</b>  |  |                         | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |                                   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |  |
| EXAMINER'S NAME (Type)<br><b>Peter V. Rieckert, E-New Market, Md.</b>   |  |                         | ADDRESS<br><b>22b. DATE SIGNED<br/>7-3-68</b>  |  |  |   |  |                                   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                         | 23b. DATE<br><b>July 3, 1968</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rhodesdale Cemetery</b>  |  |                                   | 23d. LOCATION (City or Town) (County) (State)<br><b>Near Rhodesdale, Maryland</b>               |  |  |
| 24. FUNERAL DIRECTOR<br><b>J. J. Frampton and Son, Federalsburg, Maryland</b>   |  |                         |  |  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 10 1968</b>   |  |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><i>Lula Chatman Roberts</i>  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><i>06 30 68</i> |   |  | 2b. HOUR<br>M<br><i>8:25 P</i>   |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br><i>08-15-93</i>   |  | 6. AGE (In years last birthday)<br><i>74</i> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Dorchester</i> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Rural-Cambridge</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Eastern Shore State Hosp</i>        |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>factory WORK</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>Wicomico</i>   |  | 13c. CITY OR TOWN<br><i>Bivalve</i>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br><i>John T. Neath</i>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Sarah Elizabeth White</i>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)<br><i>NO</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>214-10-9809</i>   |  | 17. INFORMANT <i>med. Records</i> Address<br><i>Eastern Shore State Hospital</i>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Infarction of myocardium</i><br><i>4109</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>arteriosclerotic coronary thrombosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>arteriosclerotic heart disease</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>minutes</i> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><i>4281</i>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Felipe M. Dominguez MD</i>   |  | DEGREE <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>7/1/68</i>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>FELIPE M. DOMINGUEZ</i>  |  | 22e. ADDRESS<br><i>ESSH Cambridge, Md</i>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE<br><i>7/3/68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Prisons Cem.</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Salisbury Md</i>                         |  |
| 24. FUNERAL DIRECTOR<br><i>C G Moser, Brandy Md.</i>  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br><i>JUL - 5 1968</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Charles Judge</i>                                      |  |

0111

RECEIVED TO THE

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*[Faint, mostly illegible handwritten text and markings, possibly bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (1)  
30M REV. 1-68

MD. STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) First MARY Middle ELLEN Last ROBINSON  |  |   | 2a. DATE OF DEATH<br>Month June Day 2, Year 1968  |  | 2b. HOUR<br>1:20AM   |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>Aug. 23, 1909   |   | 6. AGE (In years lost birthday)<br>58 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>Dorchester Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cambridge   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Cambridge Md. Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland   | 13b. COUNTY<br>Dorchester  | 13c. CITY OR TOWN<br>Toddville  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br>None             |  |
| 14. FATHER'S NAME First Shriver Middle ? Last McGlaughlin  |  | 15. MOTHER'S MAIDEN NAME First Mary Middle Ellen Last Todd  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>unk   | 17. INFORMANT Address<br>LeCompte Funeral Service records                                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral hemorrhage<br>4319<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerosis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 days           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>331X   |  |   |   |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-15-44, 19, to 6-2-68, 19, that (I) (we) lost the deceased alive on 6-1-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |   |   |  |  |
| 22b. SIGNATURE<br>Albert E. Bunker, M.D.   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   | 22c. DATE SIGNED<br>6-3-68  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>ALBERT E. BUNKER, M. D.  |  | 22e. ADDRESS<br>200 Md. Ave., Cambridge, Maryland 21613   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  | 23b. DATE<br>Jun 4, 1968   | 23c. NAME OF CEMETERY OR CREMATORY<br>Zion Methodist Churchyard   | 23d. LOCATION (City or Town) (County) (State)<br>Toddville, Maryland                            |  |  |
| 24. FUNERAL DIRECTOR<br>LeCompte Funeral Service, Cambridge, Maryland  |  | 25a. REC'D BY REGISTRAR<br>DATE JUN 7 1968  | 25b. REGISTRAR'S SIGNATURE<br>V. L. L. L.   |  |  |

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CENTRAL OF DENVER

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| NAME            | RELATION | ADDRESS                      | DATE          | REMARKS              |
|-----------------|----------|------------------------------|---------------|----------------------|
| Mr. J. H. Smith | Owner    | 1234 Main St., Denver, Colo. | Jan. 15, 1958 | Initial inspection   |
| Mr. J. H. Smith | Owner    | 1234 Main St., Denver, Colo. | Jan. 22, 1958 | Follow-up inspection |
| Mr. J. H. Smith | Owner    | 1234 Main St., Denver, Colo. | Jan. 29, 1958 | Final inspection     |
| Mr. J. H. Smith | Owner    | 1234 Main St., Denver, Colo. | Feb. 5, 1958  | Re-inspection        |
| Mr. J. H. Smith | Owner    | 1234 Main St., Denver, Colo. | Feb. 12, 1958 | Final inspection     |

Information furnished by the Denver Central Office, Colorado, on January 15, 1958, regarding the above-named property.

The property is located at 1234 Main St., Denver, Colorado. The owner is Mr. J. H. Smith. The property is a single-story building with a total area of 1,200 square feet. The building is in good condition and is being used as a residence.

The following information was obtained from the Denver Central Office:

- The property is located at 1234 Main St., Denver, Colorado.
- The owner is Mr. J. H. Smith.
- The property is a single-story building with a total area of 1,200 square feet.
- The building is in good condition and is being used as a residence.

The information was obtained from the Denver Central Office, Colorado, on January 15, 1958.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                              |  |  |                                    |   |  |   |  |  |                  |  |
|--|--|------------------------------|--|--|------------------------------------|---|--|---|--|--|------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |  |                                    |   |  |   |  |  |                  |  |
| CERTIFICATE OF DEATH   |  |                              |  |  |                                    |   |  |   |  |  |                  |  |
| 1. DECEASED-NAME (Type or print)   |  |                              | First Middle Last  |  |                                    | 2a. DATE OF DEATH   |  |   | 2b. HOUR   |  |                  |  |
| Miranda Augusta Rumbley  |  |                              |  |  |                                    | Month Day Year  |  |   | 12 3 PM  |  |                  |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |                                    |   | 6. AGE (In years last birthday)  |   | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS. |  |
| Female   |  | White                        |  | January 28, 1899   |                                    |   | 69 YRS.  |   | MONTHS DAYS  |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |   | 9. COUNTY OF DEATH   |   |  |  |                  |  |
| Md.  |  | U.S.                         |  |  |                                    |   | Dorchester Md.   |   |  |  |                  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |                  |  |
| Cambridge  |  |                              | Cambridge-Md. Hospital   |  |                                    | Homemaker   |  |   |  |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER   |  |                  |  |
| Md.  |  |                              | Dorchester   |  | Cambridge                          |   |  |   | 802 Glasgow St.  |  |                  |  |
| 14. FATHER'S NAME  |  |                              | 15. MOTHER'S MAIDEN NAME   |  |                                    |   |  |   |  |  |                  |  |
| First Middle Last  |  |                              | First Middle Last  |  |                                    |   |  |   |  |  |                  |  |
| Ernest A. Gillis   |  |                              | Effie M. Wroten  |  |                                    |   |  |   |  |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)  |  |                              | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT   |  |   | Address  |  |                  |  |
| No   |  |                              | 211-07-9503  |  |                                    | Mr. Calvin Rumbley  |  |   | Cambridge Md. 21611  |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |  |                                    |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |  |
| PART I. DEATH WAS CAUSED BY:   |  |                              |  |  |                                    |   |  |   |  |  |                  |  |
| IMMEDIATE CAUSE (a) <u>Ruptured Aortic Aneurysm</u>  |  |                              |  |  |                                    |   |  |   |  | 24 hrs                                       |                  |  |
| 4419 DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |  |                                    |   |  |   |  |  |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis - CVD</u>   |  |                              |  |  |                                    |   |  |   |  | 3 yrs  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                              |  |  |                                    |   |  |   |  |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                              |  |  |                                    |   |  |   |  |  |                  |  |
| 451X <u>Hypertension</u>   |  |                              |  |  |                                    |   |  |   |  |  |                  |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                  |  |
|  |  |                              |  |  |                                    |   |  |   |  |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |   |  |  |                  |  |
|  |  |                              | 19   |  |                                    |   |  |   |  |  |                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |   |  |  |                  |  |
|  |  |                              |  |  |                                    |   |  |   |  |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-15</u> , 19 <u>68</u> , to <u>6-17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6-16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |                                    |   |  |   |  |  |                  |  |
| 22b. SIGNATURE <u>W. J. Zimmerman</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |                              |  |  |                                    |   |  |   | 22c. DATE SIGNED <u>6-17-68</u>                                      |  |                  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |                              |  |  |                                    |   |  |   | 22e. ADDRESS   |  |                  |  |
|  |  |                              |  |  |                                    |   |  |   |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   |  | 23d. LOCATION (City or Town) (County) (State) |  |  |                  |  |
| Burial   |  |                              | 6/19/68  |  | Dorchester Mem Park                |   |  | Cambridge Dor. Md.                            |  |  |                  |  |
| 24. FUNERAL DIRECTOR <u>Kenneth R. Thomas Jr.</u> ADDRESS <u>Cambridge Md. 21611</u>   |  |                              |  |  |                                    | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                    |  |  |                  |  |
|  |  |                              |  |  |                                    | DATE <u>JUN 20 1968</u>   |  | <u>Richard J. Judge</u>                       |  |  |                  |  |

15286

UNITED STATES OF AMERICA

01110

822 15-211

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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08417

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

08422

|  |  |  |   |  |   |  |   |   |
|--|--|--|---|--|---|--|---|---|
| 1. DECEASED-NAME<br>(Type or print)  |  | First  | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year   |  | 2b. HOUR                                  |   |
| LAWRENCE   |  |  |   | SAUNDERS   | JUNE 24, 1968   |  | 11:43h                                    |   |
| 3. SEX   | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |   |
| MALE   | NEGROID  |  | MARCH 5, 1968   |  | YRS. 3  |  |   |   |
| 7a. BIRTHPLACE (State or foreign country)  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  | Md.                                       |   |
| FLORIDA  | USA  |  |   |  | DORCHESTER  |  |   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |   |
| CAMBRIDGE  | CAMBRIDGE MD. HOSP. INC.   |  | NONE  |  |   |  |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                    |   |
| MARYLAND   | DORCHESTER   |  | RHODESDALE  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | BOX 59                                    |   |
| 14. FATHER'S NAME  |  | First  | Middle  | Last   | 15. MOTHER'S MAIDEN NAME  |  | First                                     | Middle Last   |
|  |  |  | UNKNOWN   |  | LERIA   |  |   | SAUNDERS  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |   | Address  |   |   |
| NO   |  | NONE   |   | LERIA SAUNDERS   |   | PALATKA, FLA.  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BILATERAL PNEUMONIA</u><br>486X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2+ DAYS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>490X   |  |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |   |  |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-22, 19 68, to 6-24, 19 68, that (I) (we) lost<br>saw the deceased alive on 6-23, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |   |  |   |   |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |   | 22d. PHYSICIAN'S NAME (Type)   |   |  |   |   |
| Donald R. McWilliams, MD   |  | 6-26-68  |   | Donald R. McWilliams, M. D.  |   |  |   |   |
| 22e. ADDRESS   |  | 22f. ADDRESS   |   |  |   |  |   |   |
| P. O. Box 248, East New Market, Maryland   |  |  |   |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)                        |   |   |
| REMOVAL  |  | 7/1/68   |   | EVERGREEN  |   | PALATKA PUTMAN FLA.  |   |   |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |   |   |
| Frederick C. St. Clair   |  | CAMBRIDGE, MD.   |   | JUL - 9 1968   |   | Charles Judge  |   |   |

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91983



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR 415 (4)  
30M REV. 1-68

|  |  |  |  |  |       |   |             |   |  |                                |  |   |  |
|--|--|--|--|--|-------|---|-------------|---|--|--------------------------------|--|---|--|
| 08418  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |  |       | 08423   |             |   |  |                                |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle   | Last  | 2a. DATE OF DEATH<br>Month Day Year   |             | 2b. HOUR<br>10 P M  |  |                                |  |   |  |
| MYRTLE   |  |  | GRAVENOR   |  | SHORT |   | June 4 1968 |   |  |                                |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>August 5, 1890   |       | 6. AGE (In years<br>last birthday)<br>77 YRS.   |             | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED<br>WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/>               |       | 9. COUNTY OF DEATH<br>Dorchester  |             |   |  | Md.                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Galestown   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>(P.O. Seaford, Del., RFD #3)    |  |  |       | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housework |             | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Home                            |  |                                |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission)<br>STATE Maryland   |  | 13b. COUNTY<br>Dorchester  |  | 13c. CITY OR TOWN<br>Galestown   |       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |             | 13e. STREET AND NUMBER  |  |                                |  |   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>William W. Brinsfield  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Mary Wheatley |  |       |   |             |   |  |                                |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) No  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>218-10-9638                                   |  | 17. INFORMANT<br>Lester K. Short, Seaford, Del., RFD #3  |       | Address   |             |   |  |                                |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u><br>011.9<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. |  |  |  |  |       |   |             |   |  |                                |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>20 years |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>0021 Cholelithiasis  |  |  |  |  |       |   |             |   |  |                                |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |             | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |                                |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |       |   |             |   |  |                                |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State  |       |   |             |   |  |                                |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1955, 19, to June 4, 1968, that (I) (we) last<br>saw the deceased alive on June 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |       |   |             |   |  |                                |  |   |  |
| 22b. SIGNATURE<br>H.S. Kuhlman   |  | DEGREE   |  | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |       | 22c. DATE SIGNED<br>6/5/68  |             |   |  |                                |  |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>H.S. Kuhlman  |  | 22e. ADDRESS<br>Seaford Del  |  |  |       |   |             |   |  |                                |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>June 7, 1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Galestown Cemetery   |       | 23d. LOCATION (City or Town) (County) (State)<br>Galestown, Maryland                                    |             |   |  |                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>J. J. Frampton and Son, Federalsburg, Maryland   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE JUN 21 1968  |       | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |             |   |  |                                |  |   |  |

1. The first step in the process of the development of a new product is the identification of a market need. This is often done through market research, which can be conducted in a variety of ways, including surveys, focus groups, and interviews. The goal is to understand what customers want and what problems they are trying to solve.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |   |   |   |  |
|--|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Mary Lewis Byrn Simmons</b>   |   | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>18</b> Year <b>1968</b>   |   | 2b. HOUR<br><b>3 A M</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br><b>March 11, 1896</b>   | 6. AGE (In years last birthday)<br><b>72</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>HOURS MIN                                     |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Dorchester</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cambridge</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Cambridge-Md. Hospital</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Dorchester</b>  | 13c. CITY OR TOWN<br><b>Cambridge</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>Route #2</b>  |
| 14. FATHER'S NAME<br>First <b>Samuel</b> Middle <b>L.</b> Last <b>Byrn</b>   | 15. MOTHER'S MAIDEN NAME First <b>Imogene</b> Middle <b>Lewis</b> Last <b>Lewis</b>                           |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT<br><b>Mrs. Wilbur N. Baumann</b> Address <b>Cambridge Md.</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Nephritis</b><br><b>5901</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Nephrotic Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pyelonephritis</b> |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 mos</b><br><b>3 yrs</b><br><b>10 yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>6000</b>  |   |   |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 6, 1967</b> , to <b>June 18, 1968</b> , that (I) (we) last saw the deceased alive on <b>6-18</b> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |
| 22b. SIGNATURE<br><b>Wilbur N. Baumann</b>   |   | 22c. DATE SIGNED<br><b>6-21-68</b>  | 22d. PHYSICIAN'S NAME (Type)<br><b>Wilbur N. Baumann</b>  |  |
| 22e. ADDRESS   |   | 22f. ADDRESS  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>6/20/68</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Christ Churchyard</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cambridge Dor. Md.</b>                      |  |
| 24a. FUNERAL DIRECTOR<br><b>Kenneth R. Flowers</b>   |   | 24b. ADDRESS<br><b>Cambridge Md.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 26 1968</b>   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO THE SECRETARY OF THE ARMY  
 FROM THE SECRETARY OF THE ARMY  
 SUBJECT: [Illegible]  
 [The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or official communication.]

RECEIVED  
 [Illegible text in the right margin]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
I  
08420  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH  
08425

|   |                                      |   |  |  |   |  |
|---|--------------------------------------|---|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) First MARY Middle SKINNER Last  |                                      | 2a. DATE OF DEATH<br>JUNE 3 <sup>Month</sup> 1968 <sup>Day</sup> Year   |  | 2b. HOUR<br>10:30M <sup>A</sup>  |   |  |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE                     | 5. DATE OF BIRTH<br>2/8/96  |  | 6. AGE (In years last birthday)<br>72 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (State or foreign country)<br>Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>DOR.                                   |  |   | Md.  |
| 10. CITY OR TOWN OF DEATH<br>RURAL CAMBRIDGE  |                                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>EASTERN SHORE STATE HOSP.   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>HOUSEWORK                                   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |                                      | 13b. COUNTY<br>QUEEN ANNE'S   | 13c. CITY OR TOWN<br>CHURCH HILL                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET AND NUMBER  |  |
| 14. FATHER'S NAME First MIDDLE Last<br>GEORGE A. SKINNER  |                                      |   | 15. MOTHER'S MAIDEN NAME First MIDDLE Last<br>SUSIE MERCHANT |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No  |                                      | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>HOSPITAL RECORDS Address  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4109 ARTERIOSCLEROTIC HEART DISEASE WITH<br>DUE TO, OR AS A CONSEQUENCE OF CORONARY OCCLUSION<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                      |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>4201   |                                      |   |  |  |   |  |
| 19a. DATE OF OPERATION  |                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                                      | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |                                      | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 2, 1935, to JUNE 3, 1968, that (I) (we) lost the deceased alive on JUNE 3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                                      |   |  |  |   |  |
| 22b. SIGNATURE<br>Pete W. Rieckert  |                                      |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>6/3/68   |
| 22d. PHYSICIAN'S NAME (Type)<br>Pete W. Rieckert  |                                      |   |  | 22e. ADDRESS<br>E-New Market, Md   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |                                      | 23b. DATE<br>June 5   | 23c. NAME OF CEMETERY OR CREMATORY<br>Crumpton               |  | 23d. LOCATION (City or Town) (County) (State)<br>Crumpton Q.A. Maryland |  |
| 24. FUNERAL DIRECTOR<br>Edgar Lane Church Hill, Md.   |                                      |   |  | 25a. REC'D BY REGISTRAR<br>DATE JUN 10 1968  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                          |

23122

RECEIVED

23122

1

DATE: 1944

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 1944

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 1944

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 1944

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The page should be removed after death. The page should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 100  
30M REV. 1/68

| 08421   |  |  |  |  |  |  |  |  |  | 08426  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|-----------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  | 2b. HOUR   |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| ROBERT  |  |  |  |  | SMITH  |  |  |  |  | Month Day Year   |  |  |  |  | 11:10 A. M.  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 3. SEX  |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years lost birthday)  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |
| MALE  |  |  |  |  | NEGRO  |  |  |  |  | MAY 20, 1907   |  |  |  |  | 61 YRS.  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| NORTH CAROLINA  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  | DORCHESTER Md.   |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| CAMBRIDGE   |  |  |  |  | EASTERN SHORE STATE HOS.   |  |  |  |  | LABORER  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER      |  |  |  |  |                             |  |  |  |  |
| MARYLAND  |  |  |  |  | TALBOT   |  |  |  |  | EASTON   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  | First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  | First Middle Last  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| ROBERT S. SMITH   |  |  |  |  |  |  |  |  |  | FANNIE   |  |  |  |  | WOODS  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address                     |  |  |  |  |                             |  |  |  |  |
| UNKNOWN   |  |  |  |  | 240-10-4066  |  |  |  |  | E.S.S.H. RECORDS   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRAIN TUMOR</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 3 MONTHS   |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 237x  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY? BRAIN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 30, 1967</u> , to <u>JUNE 17, 1968</u> , that (I) (we) last saw the deceased alive on <u>JUNE 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 22b. SIGNATURE <u>Richard G. Bilodeau</u>   |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  |  |  |  | 22c. DATE SIGNED <u>JUNE 17, 1968</u>  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>RICHARD G. BILODEAU, M.D.</u>   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS <u>E.S.S. HOSPITAL, CAMBRIDGE, MARYLAND</u>   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| REM.  |  |  |  |  | 6/20/68  |  |  |  |  | UNIV. ANATOMICAL Bldg.   |  |  |  |  | BALTIMORE BALT. MD.  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |
| 24. FUNERAL DIRECTOR <u>Richard C. DePaie</u>   |  |  |  |  |  |  |  |  |  | ADDRESS <u>CAMBRIDGE, MD.</u>  |  |  |  |  | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |                             |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | DATE <u>JUN 24 1968</u>  |  |  |  |  |                             |  |  |  |  |                             |  |  |  |  |

5232

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |  |   |  |  |   |  |
|--|--|--|--|--|---|---|--|---|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |   |   |  |   |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or Print) <b>THOMAS</b>  |  |  | First <b>LEVIN</b>   |  |   | Middle <b>THOMPSON</b>  |  |   | Last   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br><b>April 29, 1914</b>  |   | 6. AGE (In years last birthday)<br><b>54</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____  |  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____ |   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br><b>Dorchester</b>            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Vienna - Rural</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Near Rhodesdale</b> |   |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Employee Dupont Co.</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nylon</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Dorchester</b>   |   | 13c. CITY OR TOWN<br><b>Vienna</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  | 13e. STREET AND NUMBER<br><b>R.F.D.</b>    |   |  |
| 14. FATHER'S NAME<br><b>Thomas R. Thompson</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Lettie Baltimore</b>   |   |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-07-9352</b>   |   | 17. INFORMANT<br><b>Mrs. Beulah M. Pinder, Vienna, Maryland</b>   |  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Instant</b>          |  |  |  |  |   |   |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>   |  |  |  |  |   |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____ P.M. <b>19</b> |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |   |  |   |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |  |   |   |  |   |  |  |   |  |
| ACTUAL SIGNATURE<br><b>John Mace Jr.</b><br>EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>   |  |  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) <b>Cambridge, Md.</b> |   |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>June 12, 1968</b>                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rhodesdale Cemetery</b>  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Rhodesdale, Maryland</b>  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>J. J. Frampton and Son, Federalburg, Maryland</b>   |  |  |  |  | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 18 1968</b> |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J.</b> |  |   |  |

00000

STATE OF  
NEW YORK

1887

OFFICE OF THE COMMISSIONER OF THE LAND OFFICE

TO THE COMMISSIONER OF THE LAND OFFICE  
ALBANY, N. Y.  
JANUARY 1, 1887

SIR:

I have the honor to acknowledge the receipt of your letter of the 29th inst. in relation to the above matter.

I am, Sir, very respectfully,  
Yours, very truly,  
J. B. HARRIS

JOHN B. HARRIS, Commissioner of the Land Office.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |   |   |  |            |   |  |  |
|--|--|--|---|--|---|---|--|------------|---|--|--|
| 08423  |  |  |   |  | 08428   |   |  |            |   |  |  |
| 1. DECEASED-NAME (Type or print) First ALMA Middle BREESE Last TODD  |  |  |   |  | 2a. DATE OF DEATH Month June Day 24 Year 1968   |   |  | 2b. HOUR M |   |  |  |
| 3. SEX Female  |  | 4. RACE White  |   | 5. DATE OF BIRTH July 23, 1896   |   |   | 6. AGE (In years last birthday) 71 YRS.  |            | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH Dorchester Md.   |  |            |   |  |  |
| 10. CITY OR TOWN OF DEATH Harlock  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Belle Haven Nursing Home |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker |  |            | 12b. KIND OF BUSINESS OR INDUSTRY - -                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland   |  |  | 13b. COUNTY Dorchester  |  | 13c. CITY OR TOWN Cambridge   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |            | 13e. STREET AND NUMBER 411 Robbins Street               |  |  |
| 14. FATHER'S NAME First Noah Middle Lake Last Todd   |  |  | 15. MOTHER'S MAIDEN NAME First Frances Middle ? Last Insley   |  |   |   |  |            |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No   |  |  | 16b. SOCIAL SECURITY NO. 212-16-7837  |  | 17. INFORMANT Address LeCompte Funeral Service records  |   |  |            |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4339 IMMEDIATE CAUSE (a) Cerebral Vascular Insufficiency<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332x (b) Progressive cerebral Thrombosis<br>DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Arteriosclerosis |  |  |   |  |   |   |  |            |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 yrs<br>6 yrs<br>10 yrs |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>Arteriosclerotic Parkinsonism  |  |  |   |  |   |   |  |            |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |            |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |            |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |            |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/1/68, 19, to 6/23/68, 1968, that (I) (we) lost saw the deceased alive on 6/23/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |   |   |  |            |   |  |  |
| 22b. SIGNATURE [Signature]   |  |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED 6/26/68   |            |   |  |  |
| 22d. PHYSICIAN'S NAME (Type) Harold B. Plummer M.D.  |  |  |   |  | 22e. ADDRESS Preston Mary; and Caroline   |   |  |            |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |  | 23b. DATE June 26, 1968  |   | 23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park  |   |   | 23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland                            |            |   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland   |  |  |   |  | 25a. REC'D BY REGISTRAR DATE JUN 28 1968  |   | 25b. REGISTRAR'S SIGNATURE [Signature]   |            |   |  |  |

SECRET

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-23-1993

BY SP-10

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-23-1993

BY SP-10

SIS-1-7027

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-23-1993

BY SP-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |  |  |  |   |  |   |  |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>VIOLA BANKS TRAVERS</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>11</b> Year <b>1968</b>  |   |  | 2b. HOUR<br><b>8:20a M</b>  |  |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>NEGROID</b>                  |  | 5. DATE OF BIRTH<br><b>SEPT. 29, 1905</b>   |  | 6. AGE (In years last birthday)<br><b>62</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                       |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>DORCHESTER</b> Md.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CAMBRIDGE</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>CAMBRIDGE MD. HOSP., INC.</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b>                       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>DORCHESTER</b>   |   | 13c. CITY OR TOWN<br><b>LINAS RD.</b>                              |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>RURAL</b> |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>ANTHONY R. BANKS</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>SARAH J. BROWN</b>  |   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-14-7348</b>   |   | 17. INFORMANT Address<br><b>CLARENCE TRAVERS CHURCH CREEK, MD.</b> |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of stomach</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>1519</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3 1/2 months</b> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>151X</b>  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>151X</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/25/68</b> , 19 <b>68</b> , to <b>6/11/68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6/11/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Lawrence Maryanov</b>   |  |  | DEGREE<br><b>M.D.</b>  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>6/12/68</b>     |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>LAWRENCE MARYANOV, M.D.</b>   |  |  | 22e. ADDRESS<br><b>610 RACE STREET CAMBRIDGE, MD.</b>  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>6/16/68</b>                |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LINAS ROAD Cemetery</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>LINAS ROAD DOR. MD.</b>          |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Subirick C. Delain</b>  |  |  | ADDRESS<br><b>CAMBRIDGE, MD.</b>   |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 12 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |  |  |

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UNITED STATES OF AMERICA

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08430

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |   |                                     |   |  |   |  |
|---|----------------------------------|---|-------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>DORCHESTER</u> MARYLAND   |                                  |   |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cambridge</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>26 days</u>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Marydel</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Eastern Shore State Hospital</u>   |                                  |   |                                     | d. STREET ADDRESS<br><u>NONE</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>HERBERT</u> Middle <u>WALLS</u> Last <u>WALLS</u>   |                                  |   |                                     | 4. DATE OF DEATH<br>Month <u>6</u> Day <u>4</u> Year <u>1968</u>  |  |   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>01-20-92</u> | 9. AGE (In years lost birthday) yrs.<br><u>76</u>   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> |   | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Relief Farmer</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>  </u>  |                                     | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Walter Walls</u>  |                                  |   |                                     | 14. MOTHER'S MAIDEN NAME<br><u>Emma Merchin</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>  </u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>221-165478</u>  |                                     | 17. INFORMANT<br><u>Records of the Eastern Shore State Hosp.</u> Address <u>  </u>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PNEUMONIA, TERMINAL</u><br><u>2509</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260X</u><br>(b) <u>DIABETES MELLITUS</u> DUE TO<br>(c) <u>  </u> |                                  |   |                                     |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 DAYS</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u>   |                                  |   |                                     |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>   |                                     |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>   |  | 20f. (City or town) (County) (State)<br><u>  </u>   |  |
| 21. I certify that <u>  </u> (this hospital) attended the deceased from <u>5-10-</u> , 19 <u>68</u> , to <u>6-4</u> , 19 <u>68</u> , that <u>  </u> (we) last saw the deceased alive on <u>6-4</u> , 19 <u>68</u> , and that death occurred at <u>4:55 p.m.</u> , from causes and on the date stated above.   |                                  |   |                                     |   |  |   |  |
| 22a. SIGNATURE<br><u>Miguel A. de la Guardia</u>  |                                  |   |                                     | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>        |  | 22b. DATE SIGNED<br><u>6/4/68</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>MIGUEL A. de la GUARDIA, M.D.</u>  |                                  |   |                                     | 22d. ADDRESS<br><u>E. S. S. H.</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>June 8</u>  |                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Templeville</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Templeville, Md.</u>                          |  |
| 24. FUNERAL DIRECTOR<br><u>John E. Bawls</u>  |                                  |   |                                     | 25a. REC'D BY REGISTRAR<br>DATE <u>JUN 10 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08426

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 13e, Film 401 6/MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08431

|  |  |   |  |  |  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>RUTH</b>  |  | First <b>Mitchell</b>                         |  | Middle <b>Warren</b>   |  | Last  |  | 2a. DATE KNOWN OF DEATH<br>Month <b>June</b> Day <b>10</b> Year <b>1968</b>                                    |  | 2b. HOUR<br><b>8:15</b> M                        |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>                       |  | 5. DATE OF BIRTH<br><b>3-14-1913</b>   |  | 6. AGE (In years last birthday)<br><b>55</b> YRS. |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>separated</b> |  | 9. COUNTY OF DEATH<br><b>Dorchester</b>           |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>June</b> Day <b>10</b> Year <b>1968</b>                                   |  | 2d. HOUR<br><b>8:15</b> M                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cambridge</b>  |  |   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Eastern Shore State Hospital</b>  |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Laundry Work</b> |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |   |  | 13b. COUNTY<br><b>Worcester</b>  |  |   |  | 13c. CITY OR TOWN<br><b>Berlin</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>Unknown</b>   |  |   |  | 14. FATHER'S NAME<br>First <b>Edward</b> Middle <b>Mitchell</b> Last <b>Marshall, Ruth</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Anna</b> Middle <b>Marshall, Ruth</b> Last <b>Anna</b>                    |  |  |  | 16. SOCIAL SECURITY NO.<br><b>not listed</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>unknown</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>not listed</b>  |  |   |  | 17. INFORMANT<br><b>Medical Records Eastern Shore State Hosp.</b>  |  |  |  | ADDRESS  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPHYXIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MASSIVE ASPIRATION OF FOOD PARTICLES</b><br>(c) <b>FOLLOWING ATTEMPT AT DROWNING.</b>   |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>979X</b>  |  |   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>958X</b>  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY Month, Day, Year<br>Hour A.M. <b>19</b> P.M. <b>19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Peter W. Rieckert</b>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  | 22b. DATE SIGNED <b>6-11-68</b>  |  |  |  |  |  |
| EXAMINER'S NAME (Type) <b>PETER W. RIECKERT, M.D.</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |  |  |
| ADDRESS (Street, city, town, or county) <b>EAST NEW MARKET, MD.</b>  |  |   |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |   |  | 23b. DATE<br><b>6/13/68</b>  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>EVERGREEN</b>   |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BERLIN WOR. MD</b>   |  |   |  | 24. FUNERAL DIRECTOR<br><b>Anna A. Penbaze Berlin Md</b>   |  |  |  |  |  |
| 25a. REC'D BY REGISTRAR<br>DATE <b>JUN 13 1968</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |  |  |  |  |  |  |  |

1250



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME-5  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Dorchester</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cambridge</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Federalsburg</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>E.S.S.H.</u>   |   | d. STREET ADDRESS<br><u>Academy Ave.</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Charles</u> Middle <u>J.</u> Last <u>Williams</u>   |   | 4. DATE OF DEATH<br>Month <u>6</u> Day <u>23</u> Year <u>1968</u>   |   |
| 5. SEX<br><u>m</u>  | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1-21-80</u>  |
| 9. AGE (In years last birthday)<br><u>88</u> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer Factory</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Laborer</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>William Williams</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>PACKS</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>  |   | 16. SOCIAL SECURITY NO.<br><u>218-20-7205</u>   |   |
| 17. INFORMANT<br><u>Elsie Williams</u>  |   | Address<br><u>Federalsburg</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>887X</u> <u>Terminal Pneumonia</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heart Attack</u><br>DUE TO<br>(c) <u></u>   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>17 days</u>                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>9047</u>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.<br><input type="checkbox"/>   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>fell in hospital</u>                                     |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>6</u> <u>4/5/1968</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)<br><u>Hospital</u>   | 20f. (City or town) (County) (State)<br><u>Cambridge</u> <u>Dor.</u> <u>md.</u>                   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE <u>John Mace Jr</u> M.D.   |   | 22. DATE SIGNED<br><u>6/13/68</u>   |   |
| EXAMINER'S NAME (Type) <u>JOHN MACE JR</u>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br><u>Federalsburg, Car. Md.</u>                     |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>June 24, 1968</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Vincent Cem.</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Federalsburg, Car. Md.</u>                    |
| 24. FUNERAL DIRECTOR<br><u>Henry Williams - Federalsburg, Md.</u>   |   | 25a. REC'D BY REGISTRAR<br><u>JUL - 1 1968</u>  |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |

1812

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5-54-68  
30M REV 11/68

1  
08428

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

38433

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>WILLIAM HENRY WILMER  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>JUNE 6, 1968 |   |  | 2b. HOUR<br>9:45 A.M.   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>NEGRO  |   | 5. DATE OF BIRTH<br>2/7/84  |  | 6. AGE (In years last birthday)<br>84 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br>DORCHESTER Md.  |  |
| 10. CITY OR TOWN OF DEATH<br>RURAL CAMBRIDGE   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>EASTERN SHORE STATE HOSP.         |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>NONE   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  | 13b. COUNTY<br>TALBOT   |   | 13c. CITY OR TOWN<br>UNIONVILLE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>Rt. 1, Box 238   |  | 14. FATHER'S NAME First Middle Last<br>WILLIAM WILMER   |   |   |  |   |  |
| 15. MOTHER'S MAIDEN NAME First Middle Last<br>- Jennie Wilmer  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>NO |   |   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>214-12-6439  |  | 17. INFORMANT<br>HOSPITAL RECORDS   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>485X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>491X</u> |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Cachexia due to Cerebrovascular accident.</u>  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                      |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>68</u> , to <u>6/6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6/6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br>Carlos F. Barroso MD   |  | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br>6-6-68  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>CARLOS F. BARROSO MD   |  | 22e. ADDRESS<br>S. Main St. Haverhill Md  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>June 11, 68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Richards Cem  |  | 23d. LOCATION (City or Town) (County) (State)<br>Easton Talbot Md                               |  |
| 24. FUNERAL DIRECTOR<br>George H. Norbuhl  |  | ADDRESS<br>Easton Md  |   | 25a. REC'D BY REGISTRAR<br>DATE JUN 12 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>John A. Judge   |  |

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*[The main body of the document contains several lines of extremely faint, illegible text, likely bleed-through from the reverse side. The text is arranged in a structured format, possibly a list or a series of entries, but the characters are too light to transcribe accurately.]*

*[Faint vertical text along the right edge, possibly a page number or a reference code.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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08429

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

08434

|   |                         |   |   |   |  |
|---|-------------------------|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>WILLIAM M WOOTTEN</b>   |                         |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>JUNE 9 1968</b>                 |   | 2b. HOUR<br><b>7<sup>50</sup> PM</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br><b>02-14-85</b>   |   | 6. AGE (In years lost birthday)<br><b>83</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. COUNTY OF DEATH<br><b>DORCHESTER</b>   |                         | Md.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CAMBRIDGE</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>EASTERN SHORE STATE HOSP</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>RETIRED</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |                         |   |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br><b>MARYLAND</b>  |                         | 13b. COUNTY<br><b>WORCESTER</b>   | 13c. CITY OR TOWN<br><b>SNOW HILL</b>                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER<br><b>FEDERAL STREET</b>  |
| 14. FATHER'S NAME First Middle Last<br><b>LUCE IN WOOTTEN</b>   |                         |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>EMMA PARSONS WOOTTEN</b> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>NO</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>110 212-16-1492</b>  |   | 17. INFORMANT<br><b>RECORDS OF THE EASTERN SHORE STATE HOSPITAL</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>EMPHYSEMA + CHRONIC BRONCHITIS</b>                                 |                         |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 HRS</b><br><b>48 HRS.</b><br><b>5 + YRS.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>5020 CACHEXIA + GENERALIZED ARTERIOSCLEROSIS.</b>  |                         |   |   |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                         |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/16, 1967</b> , to <b>06/09, 1968</b> , that (I) (we) lost saw the deceased alive on <b>06/09, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |                         |   |   |   |  |
| 22b. SIGNATURE<br><b>Sean M Killoran</b> M.D. DEGREE  |                         |   |   | 22c. DATE SIGNED<br><b>June 9, 1968</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>SEAN M. KILLORAN</b>   |                         |   |   | 22e. ADDRESS<br><b>7415 BLAIR RD, WASHINGTON, D.C.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>6/12/68</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>EVERGREEN</b>                    |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BERLIN WDR MD</b>                              |
| 24. FUNERAL DIRECTOR<br><b>Anna A. Burbage</b>  |                         |   | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>                           |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |

100-100000

RECEIVED ON DEATH

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DATE OF BIRTH: JUNE 10, 1900

DATE OF DEATH: 07-14-52

WHITE

MALE

HARTLAND, USA

ROCHESTER

EASTERN HOME STATE HOSP

ROCHESTER

HARTLAND, NEW YORK

2ND FLOOR

FEDERAL STAFF

LUCE, JAMES

2ND

ROCHESTER

NO. 100-100000

*[Faint, mostly illegible text and markings covering the bottom half of the page, possibly bleed-through or a second document.]*